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Revisional Surgery: An Inevitable Practice

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Revisional surgery means, today, an inevitable practice to every surgeon performing with bariatric or metabolic surgery and they need to learn to deal with.

Such an experience is considered by the most important behavioral scientific societies as a mandatory capability in the set of requests a bariatric Surgeon should fulfill.

Obesity, based in genetic and behavioral causes is clearly a difficult disease to treat and, even after Bariatric surgery, the exceptional human body capacity to defeat the surgical trauma formerly suffered is enormous. Loss of restriction, hunger recovery, new alimentary behavior shifts, are the main reasons for the relapses and recurrences we are used to observe in a certain percentage of the patient we treat with an initial success but latterly lost because of the readaptative phenomena, whatever is the chosen surgical technique.

Nowadays, many patients are coming back some years later complaining of weight regain, accordingly to the statistics, The ones who have dropped out for follow-up are, naturally more prone to suffer such a course. Those patients usually don't blame the operation but, more consistently, themselves. But, if in our practice we can see and recognize that truth in the majority of the cases, but we are able to recognize some anatomical or functional losses as well. And, of course, we need to diagnose some unrevealed complications too; some of them may be linked to the weight regain, like gastro-esophageal reflux, gastro-gastric fistulae or fundus dilation.

In all cases we need to offer the patients some kind of solution. In all the patients we should strive to study the case with a psychological and nutritional reevaluation. Gastrointestinal series and endoscopies should be asked and laboratorial status redefined. The knowledge of the surgical report of the previous operation is strongly advised because of operational and medico-legal reasons.

The surgical previous operative report request is strongly advised because of operational and medico-legal reasons. Sometimes patients have video records that may be very helpful.

We should never skip those steps otherwise we are leading the patient, and ourselves, in a risk for a disgusting new failure. And some of them, after this kind of protocol, should not be candidates for revisional surgery because we must be conscientious of our limited ability to control the Nature. Clearly some kind of patients because of a psychiatric profile or an outstanding power to beat even the strongest malabsorptive effect should stay free of our, some time desperate, care.

In the remaining cases, the modern Bariatric surgeon needs to be wise enough to find a good surgical upgrade to his patient, and skilled enough to approach surgically the situation respecting, first of all, the safety issues. If someone believes he is not proficient enough to a difficult laparoscopic operation, for instance by laparoscopy, he may go for an open surgery, may be with the assistance of a more experienced colleague. Basic principles like the one who says it's dangerous to combine strong restriction and strong malabsorption should be understood and considered in the moment of the operative decision.

Old but sharper challenges to the surgeon are evaluations like the nutritional status, the immunological profile, the inflammatory chronic states or the associated anatomical changes like eventrations, intra-abdominal adhesions, intense fibrosis or organic dysmorphies. All of them are able to distress the easiest surgeon and provide a good chance to test his conceptual solidity, quick thinking and improvisation capacity, and technical skill. And, very important, to check the ability to stop whenever he is running too much risks and getting a chance of harming the patient in a definitive way.

Strictly in the technical surgical point of view, we must pay attention to the some iatrogenic lesions like a hollow viscera rupture or an organ devascularization and consequent ischemia. Hemorrhages are more frequent and important and anastomosis performed sometimes in a certain distance from the ideal conditions.

All of those difficulties have to be anticipated before the operation day. Even though, all the gathered information may be insufficient to avoid intraoperative surprises. So, like good militar generals do, a good operative strategy and an alternative plan must be carefully prepared.

In this kind of set up it is not so strange about revisional surgery increased morbid mortality rates. But the literature shows such an increase may be reduced to near zero with the accumulated number of performed cases. In our practice we performed some hundreds of conversions from band to gastric bypass. In the first 100 cases we have had three times more complications, but not mortality, than the primary bypasses. After the first 150 cases the rate was only the double and after two hundred cases it was the same of the bypasses performed as an initial bariatric operation.

Every surgeon needs to consider "experience" as something that comes from living repeated difficult situations where we may learn to avoid mistakes and choose the good trends. But this does not implies to run all the mistakes by himself and learning and training courses attendance, as well as the chance to observe and discuss clinical cases with an experienced surgeon, may be the best policy to avoid too much unhappy and stressful occasions.

Independently of the individual evolutional course we would like to stress that we need to have a clear view that is enough to consider the patient safety which is our main goal together with efficiency, to be successful in revisional surgery.